



# AMERICAN BENEFITS COUNCIL

October 8, 2009

## PRIORITY EMPLOYER ISSUES FOR SENATE CONSIDERATION OF HEALTH CARE REFORM

### PRIORITY HEALTH REFORM PROVISIONS

#### I. ERISA

(Retain Exclusive Federal Regulation of Self-insured Employer Plans)

**Council Position:** The regulatory framework established by the Employee Retirement Income Security Act of 1974 (ERISA) makes it possible for multi-state employers to provide uniform benefits to their employees and consistently administer these essential benefits without being subject to conflicting state or local regulations. All employers that offer health benefits to employees who live in different states -- and potentially every state -- consider the ERISA regulatory framework to be absolutely essential and vital to their ability to have a consistent benefits strategy for their entire workforce.

**Recommendation:** We urge that no amendments be adopted that would undermine the ability of employers to maintain and administer their plans as uniformly and efficiently as possible. We also urge that no provisions be included that would permit state waivers of ERISA since this would also lead to state-by-state regulation of employer-sponsored self-insured plans and would significantly increase the cost and complexity of health benefits sponsored by multi-state employers

#### II. Employer "Pay or Play" Mandate

(Oppose Possible Kerry Employer Mandate Amendment)

**Council Position:** We recognize that health care reform will also involve new responsibilities for employers and we believe the provisions in the Senate Finance Committee bill strike an appropriate balance between establishing new duties for employers while recognizing that employers must have flexibility to design benefit

plans that meet the unique needs of their workforce. In addition, the Finance Committee's approach permits employees to obtain income-based tax credits for coverage in a health insurance exchange if their share of the cost for their employer plan is unaffordable or if the plan has a low actuarial value.

**Recommendation:** We oppose the more costly, coercive and disruptive employer "pay or play" provisions in both the Senate HELP Committee bill and the House Tri-Committee bill. These other approaches would penalize employers for not offering health coverage unless it meets highly prescriptive, "one-size-fits-all" standards set by federal regulations.

We are very concerned that ultimately, if unintentionally, the cumulative effect of these requirements will lead to a net reduction in employer-sponsored coverage by leading some companies to simply "pay" rather than "play. This would lower the level of active employer engagement and the important role employers play as innovative and demanding purchasers of health care services. Making health care coverage more affordable for employers of all sizes is the best way to ensure the continuation of the extremely high level of participation by larger employers in offering health coverage and increase the level of participation by smaller employers who are struggling to make health coverage a reality for their employees.

### **III. Employee Opt-Out from Employer Plan**

(Oppose Possible Wyden "Free Choice" Amendment)

**Council Position:** Under any of the health reform proposals under consideration by Congress, an employee may decline coverage under an employer plan, and elect coverage through the newly established health insurance exchanges. However, we believe that it would be highly destabilizing to employer-sponsored coverage if those who leave their plan were entitled to a "voucher" from their employer to purchase coverage in the insurance exchanges.

**Recommendation:** Employers should not be required to subsidize employees who decline coverage under an employer plan and opt to obtain coverage elsewhere. Under this approach, employees who remain in the employer's plan would lose the value of the premium contributions from their co-workers who opt-out and obtain coverage in the insurance exchanges. This would result in higher costs for the plan sponsor as well as the employees who participate in the employer plan. This approach would also reduce the employer's purchasing leverage when negotiating with insurers or benefit administrators for the plans offered to their employees. Again, this reduced leverage would result in added costs paid by employers and employees.

These problems are not cured by limiting the availability of the voucher to those cases where the employer provides fewer than two plan choices. Some employers have

moved to providing a single health plan choice in order to maximize their purchasing power and deliver the most affordable plan they can to their employees and minimize the added costs that accompany the offering of multiple plan options. Employers would no longer be permitted to offer a single health plan choice under the “Free Choice” amendment unless the employer also complied with the voucher requirements and risk the destabilizing effects that would result from that approach as employees opt-out of the employer’s plan.

#### **IV. Public Plan Option**

(Oppose Possible Rockefeller and/or Schumer Public Plan Option Amendments)

*Council Position:* We recognize that the public plan option issue and possible alternatives are still under consideration. Our views on this issue have consistently been that we believe that vibrant competition among private health plan options in a reformed market should be given every opportunity to succeed. Transitioning from the market rules in place today, to a reformed market with new insurance exchanges available in every state is a dramatic change in current practices. Achieving a reformed and well regulated private market is essential and should be a central focus of health care reform. This core element of health reform will be challenging enough without attempting to introduce public plan options that risk destabilizing the insurance market at the same time it will be undergoing significant change and meeting demanding new standards.

*Recommendation:* We urge Congress to reject the government-sponsored public plan option in either the Senate HELP bill or the House Tri-Committee bill. We also oppose any option that permits a public plan to use Medicare payment rates -- even for a temporary start-up period -- as this will increase cost-shifting to private payers and give a public plan an unfair market advantage over private plan competitors. Employers will already be facing an increasing cost-shift burden under this legislation because of reductions in Medicare payments to providers and expansions in Medicaid eligibility. Finally, while potentially less disruptive, we do not believe that the non-profit, member-run cooperative option in the Senate Finance Committee’s bill is needed to achieve meaningful choice or robust competition in the reformed insurance marketplace.

#### **V. Workplace Wellness Programs**

(Retain Enzi/Harkin and Carper/Ensign Provisions in Senate Bills)

*Council Position:* Workplace wellness programs help to reduce health costs, improve productivity, and promote personal responsibility for achieving and maintaining a healthy lifestyle. Provisions included in both the Senate HELP bill and the Senate Finance Committee bill, with bipartisan support, allow for increasing the premium

discounts that employers may use to encourage employer participation in workplace wellness programs and are an important component of health care reform.

**Recommendation:** We strongly support retaining provisions in the Senate HELP Committee bill and the Senate Finance Committee bill that permit employers to discount up to 30 percent of the premium for employee-only coverage for participants in a workplace wellness program (with discretion given to the Secretary of Health and Human Services to permit discounts up to 50 percent). The Senate HELP and Finance Committee provisions also codify current law protections in HIPAA regulations to safeguard the privacy of employee health information and to assure that wellness programs meet appropriate non-discrimination standards. For example, any rewards offered by the employer must be available to all “similarly situated” individuals. In addition, there must be a reasonable alternative available to those for whom medical conditions prevent them from achieving the reward, or for whom it is medically inadvisable to attempt to achieve the reward.

## **VI. Insurance Market Reform**

(Establish Adequate Incentives for Individuals to Obtain and Maintain Coverage)

**Council Position:** A reformed and stable insurance market requires broad participation so that individuals do not wait to obtain health insurance only when they or a member of their family has an imminent need for medical services. Achieving broad participation in the marketplace requires a combination of minimum standards that assure the availability of affordable coverage and adequate financial incentives to encourage individuals to obtain and maintain coverage.

**Recommendation:** We support efforts to broaden the availability of low-cost coverage to satisfy the individual mandate requirement, particularly for individuals who are not otherwise able to afford “bronze” level health coverage (the lowest level coverage available in a health insurance exchange) and might otherwise elect not to purchase health coverage at all. We also believe that penalties for not obtaining health insurance coverage under the Senate HELP Committee bill and the Senate Finance Committee bill need to be re-evaluated in order to ensure that a sufficient financial incentive is established to maximize enrollment and encourage continuous coverage.

## **PRIORITY REVENUE PROVISIONS**

### **I. High Cost Plan Excise Tax**

(Make Further Changes to the Tax Thresholds, Indexing and Benefits Subject to the 40 Percent Excise Tax)

**Council Position:** While we commend the Senate Finance Committee for several changes in the high cost plan excise tax that were approved as amendments during the committee's mark-up, we believe that they do not go far enough. These changes included increases in the tax thresholds for retirees and those in high risk occupations, indexing the tax thresholds by CPI + 1 percent and permitting coverage for pre-65 and post-65 retirees to be combined when determining the value of coverage offered to retirees.

Despite these changes, large numbers of employer plans (both public and private) are certain to exceed the new tax thresholds, not because they offer "Cadillac" or "gold-plated" benefits, but simply because health care costs are increasing by an average of 7 or 8 percent a year while the tax thresholds would be indexed to CPI + 1 percent and therefore will increase at a much lower rate than health care costs. Health plan costs may also be higher than average because of geographic variations and the average age of the workforce. Because of these factors, eventually a large number of employers could face payment of the 40 percent excise tax unless significant benefit changes are made to avoid these costs.

**Recommendation:** We strongly urge that additional changes be made in the high cost plan excise tax to make it fairer, less disruptive and less likely to result in diminished coverage for employees and retirees, including:

- Increase the tax thresholds so that fewer plans would face immediate taxation in 2013;
- Provide a multi-year transition rule for plans already above the thresholds in tax year 2010;
- Index the tax thresholds by the medical component of CPI, or at a minimum, by a blend the CPI and the medical component of CPI;
- Establish a "safe harbor" for plans that would not be subject to the excise tax, such as plans that do not exceed the actuarial value of a "silver" plan in the health insurance exchanges;
- Do not count employee contributions to health care in determining the amounts applied toward the thresholds. In particular, amounts paid by employees on an after-tax basis should not be included in the thresholds since these employee payments have already been taxed;
- Exempt retiree health plans from the excise tax so that employers who offer these valuable plans are not penalized for doing so and so that the tax does not further contribute to the costs of these benefits or employers' liability for sponsoring them;
- Do not count contributions to flexible spending arrangements, health savings accounts, dental, vision or other supplementary benefits in determining amounts applied toward the thresholds;
- Maintain the initial year increase in the thresholds for high-cost states on a permanent basis;

- Exempt employers from the excise tax if they offer multiple plan options that have an aggregate average value below the tax thresholds.

## **II. Premium Taxes on Employer Plans**

(Eliminate New Federal Premium Taxes on Employer Plans)

*Council Position:* The Senate Finance Committee bill would also directly raise employers' health care costs by adding new federal premium taxes on their health plans to fund comparative effectiveness research, reinsurance for the individual insurance market and reinsurance for qualified retiree health care claims. These amounts will also increase employer and employee costs for health coverage and establish an inappropriate precedent for meeting future revenue needs by taxing employer-sponsored health coverage.

*Recommendation:* We strongly support the worthwhile objectives of the comparative effectiveness program and the reinsurance programs for the individual insurance market and the retiree health reinsurance program, but support amendments to eliminate the premium taxes for funding these programs and recommend that they be funded in the same manner as all other new requirements in the legislation.

## **III. Health Industry "Fees"**

(Reduce or Eliminate Fees that Will Increase Employer and Employee Costs)

*Council Position:* We also are very concerned that the majority of the total of \$121 billion in "fees" over the next ten years that the Senate Finance Committee bill would require to be paid by insurers, pharmaceutical and medical device manufacturers will ultimately be paid by employers and employees in the form of increased health care premiums. The Congressional Budget Office has also advised Congress that these "fees" will result in higher premiums and therefore will increase costs to both purchasers and consumers.

*Recommendation:* We support amendments to reduce or eliminate the health industry "fees" that will inevitably result in increased costs for employers and employees who are already struggling to maintain affordable health coverage.

## **IV. Taxation of Retiree Prescription Drug Subsidies**

(Continue to Exclude Retiree Prescription Drug Subsidies from Taxation)

*Council Position:* The Medicare Modernization Act provided subsidies to encourage employers to maintain retiree drug coverage for their Medicare-eligible retirees and excluded these subsidies from taxation so that as many employers as possible would

continue this valuable benefit for their retirees. Employers who retain this benefit save federal funds since it costs more for Medicare to provide the same benefits to its beneficiaries than what is spends to encourage employers to maintain this coverage.

**Recommendation:** We recommend that retiree drug subsidy payments to employers who maintain prescription drug coverage for their Medicare-eligible retirees continue to be excluded from taxation. Taxation of these amounts will lead to more Medicare-eligible retirees obtaining coverage in the Medicare Part D program rather than through their employer, resulting in unnecessarily higher and avoidable costs to taxpayers.

## **V. Contribution Limits on Flexible Spending Accounts** (Increase and Index Contribution Limits to FSAs)

**Council Position:** Limiting contributions to employee flexible spending accounts (FSA) will raise health care costs for individuals with high unreimbursed health care expenses, including chronically or seriously ill individuals with costly prescription drug or medical equipment needs.

**Recommendation:** We support increasing and indexing the \$2500 annual FSA contribution limit included in the Senate Finance Committee bill. We also urge that any limit be accompanied by a report by the appropriate agencies to determine the impact of contribution limits on individuals with chronic illness or other serious health conditions with recommendations to Congress on how to mitigate such adverse impact.